

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE		INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
<input type="radio"/> YES <input type="radio"/> NO				
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
	<input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> DEPENDENT			
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS	
SECONDARY COVERAGE		INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
<input type="radio"/> YES <input type="radio"/> NO				
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
	<input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> DEPENDENT			
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers	<input type="radio"/>	<input type="radio"/>	1.
Insurance Companies	<input type="radio"/>	<input type="radio"/>	2.

CONFIRMATIONS



DO YOU PREFER A CONFIRMATION CALL

No, it is unnecessary Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME		LAST,	FIRST	MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PREFER TO BE CALLED			HOME PHONE #			CELL PHONE #	
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP	E-MAIL
MARITAL STATUS		PATIENT'S / GUARDIAN'S EMPLOYER				OCCUPATION	
<input type="radio"/> S <input type="radio"/> M <input type="radio"/> W <input type="radio"/> D <input type="radio"/> UNDER AGE 18							
WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP	WORK PHONE #
SPOUSE'S NAME		LAST,	FIRST	MI	SPOUSE'S EMPLOYER		OCCUPATION
SPOUSE'S WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP	WORK PHONE #
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE					WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?		

EMERGENCY CONTACT INFORMATION**PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)**

NAME		RELATIONSHIP	
HOME PHONE #	WORK PHONE #	CELL PHONE #	

REQUEST FOR CONFIDENTIAL COMMUNICATION**AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:**

	YES	NO
Contact me at home	<input type="radio"/>	<input type="radio"/>
Contact me via cell phone	<input type="radio"/>	<input type="radio"/>
Contact me at work	<input type="radio"/>	<input type="radio"/>
Contact me via e-mail	<input type="radio"/>	<input type="radio"/>
Leave messages on my home voicemail / answering machine	<input type="radio"/>	<input type="radio"/>
Leave messages on my cell phone voicemail	<input type="radio"/>	<input type="radio"/>
Leave messages on my work voicemail / answering machine	<input type="radio"/>	<input type="radio"/>

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



- Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
- Have you had an unfavorable dental experience? _____
- Have you ever had complications from past dental treatment? _____
- Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
- Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
- Have you had any teeth removed? _____

GUM AND BONE



- Do your gums bleed or are they painful when brushing or flossing? _____
- Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
- Have you ever noticed an unpleasant taste or odor in your mouth? _____
- Is there anyone with a history of periodontal disease in your family? _____
- Have you ever experienced gum recession? _____
- Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
- Have you experienced a burning sensation in your mouth? _____

TOOTH STRUCTURE



- Have you had any cavities within the past 3 years? _____
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
- Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
- Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
- Do you have grooves or notches on your teeth near the gum line? _____
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
- Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT



- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
- Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____
- Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
- Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
- Are your teeth crowding or developing spaces? _____
- Do you have more than one bite and squeeze to make your teeth fit together? _____
- Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
- Do you clench your teeth in the daytime or make them sore? _____
- Do you have any problems with sleep or wake up with an awareness of your teeth? _____
- Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS



- Is there anything about the appearance of your teeth that you would like to change? _____
- Have you ever whitened (bleached) your teeth? _____
- Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
- Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:		YES	NO		YES	NO	
1.	hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	an allergic reaction to			27.	arthritis, rheumatoid arthritis, lupus _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28.	glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> penicillin			29.	contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> erythromycin			30.	head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> tetracycline			31.	epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> sulfa			32.	neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> local anesthetic			33.	viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> fluoride			34.	any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> metals (nickel, gold, silver, _____)			35.	hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> latex			36.	STI/STD _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> other _____			37.	hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3.	heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38.	HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39.	tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40.	radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41.	chemotherapy, immunosuppressive _____	<input type="checkbox"/>	<input type="checkbox"/>
7.	artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42.	emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8.	rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43.	psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9.	high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44.	antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10.	a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45.	alcohol / street drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11.	anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:			
12.	prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	46.	presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
13.	emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
14.	tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	48.	taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
15.	asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	49.	taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	50.	often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
17.	kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51.	experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
18.	liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	52.	a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
19.	jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	53.	considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
20.	thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54.	often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21.	hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	55.	FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22.	high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	56.	FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23.	diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	57.	MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24.	stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>				
25.	digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>				

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

